STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING _____ B. WING _____	C 04/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review and interview, the facility failed to notify the	F 157	F 157 1. What corrective action(s) will be accomplished for those residents found to have been affected: On 11/21/11 the Director of Nursing audited resident #2's chart for possible compromised clinical status with none observed. On 4/24/12 patients condition is stable with no significant change of status related to tube feeding. On 11/23/11 the Director of Nursing completed individual education with nurse #3 regarding notifying the physician of changes in resident condition. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? As of 4/24/12 resident #2 is the only resident receiving tube feeding per physican order in the facility. On 12/8/11 and 3/30/12, the Staff Development Coordinator (RN) and Nursing Supervisor provided in-services to licensed nurses (LPN and RN) on notifying physician of change of condition in residents receiving tube feedings. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? The Director of Nursing or nursing supervisor (LPN or RN) will complete an audit daily for one month, then weekly for two months of physician notification for change in condition for residents receiving tube feeding.	4/24/2012 4/24/2012 4/24/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 4/24/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APR 26 2012

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F 157	Continued From page 1 physician of a change in condition and the need to alter treatment for one (#2) of six residents reviewed. The findings included: Resident #2 was admitted to the facility on August 25, 2005, with diagnoses including Senile Delusions, Hypertension, Urinary Retention, Severe Alzheimer's Disease, Diabetes, Cerebral Vascular Accident (Stroke), History of Melanoma, History of Hypotensive Shock and Respiratory Arrest requiring ventilation and PEG (Percutaneous Endoscopic Gastrostomy) tube placement (August 2005). Medical record review of the Minimum Data Set (MDS) dated January 7, 2012, revealed the resident had short and long-term memory problems and severely impaired decision-making skills; had no behavioral symptoms; was totally dependent on staff (one to two staff) for all activities of daily living (ADL); required a feeding tube with 51% (percent) or more total calories provided with tube feeding; and had an average fluid intake by tube feeding of 501 cc (cubic centimeter) or more per day. Medical record review of the physician's recapitulation orders dated November 1-30, 2011, revealed, "...Glucerna (prepared tube feeding)...60 ml (milliliter) (per) hour (720 ml per twelve hour nursing shift)...Check residual every 4 hours-If greater than 100 ml, turn feeding off for 2 hours then restart..." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated	F 157	F 157 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place. The Director of Nursing or designee will review the tube feeding audit and will report findings monthly times three months to the members of the Performance Improvement Committee including the Medical Director, Executive Director, Pharmacist, Director of Business Development, Business Office Manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. They will review the findings, make recommendations, and make plans of action if any areas are found to be noncompliant.	4/24/2012

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F 157	Continued From page 2 November 4, 2011, at 10:00 p.m., revealed, "...feeding held due to more than 30 cc residual-Abd (Abdomen) distended-Will monitor (with) feeding off." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated November 13, 2011, at 10:00 p.m., revealed, "...Feeding pump off @ (at) this time due to residual (no amount documented) and shaking hands...G (Gastrostomy) tube patent & (and) intact..." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated November 18, 2011, at 10:00 p.m., revealed, "...noted 60 cc plus residual-feeding held-tube patent & flushed well-will continue to monitor." Review of the tube feeding intake and output flowsheet revealed the following: November 4, 2011, 250 cc tube feeding was administered 6:00 p.m.-6:00 a.m., (night shift) by LPN #3; November 13, 2011, LPN #3 100 cc tube feeding was administered by LPN #3 on night shift; and November 18, 2011, LPN #3 held the tube feeding "due to lg (large) amt (amount) residual (no amount documented)". Review of the facility's policy for physician notification, entitled, "Changes in Resident's Condition or Status" revealed, "The facility will notify the resident, his/her attending physician, and representative...of changes in the resident's condition and/or status. The following will outline the process...Nursing services will be responsible for notifying the resident's attending physician when:...There is significant change in the	F 157		

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F 157	Continued From page 3 resident's physical, mental, or emotional status...There is a need to alter the resident's treatment or medications significantly...All notifications must be made as soon as practical, but in no case will such notification exceed twenty-four (24) hours..." Medical record review and interview on March 27, 2012, at 10:45 a.m., in the conference room, with LPN #3 confirmed the physician ordered the tube feeding held for two hours if the residual was 100 cc and confirmed LPN #3 held the tube feeding on November 4, 2011, with a residual of 30 cc. Continued interview confirmed LPN #3 failed to notify the physician the tube feeding was held for residual of 30 cc instead of 100 cc as ordered. Continued interview confirmed LPN #3 held the tube feeding on November 13, 2011, because the resident's hands were shaking and LPN #3 was "afraid would go into Seizures and aspirate". Continued interview confirmed LPN #3 failed to notify the physician of the change in the resident's condition and the tube feeding being held. Continued interview confirmed LPN #3 held the tube feeding on November 18, 2011, with a residual of 60 cc. Continued interview revealed LPN #3 gave medications at the 8:00 p.m., medication pass; had "trouble" administering the medications; waited a "couple of hours...got 60 cc residual...held the tube feeding...second residual was 60 cc...Abdomen was distended...Tube feeding was off all night." Continued interview confirmed LPN #3 did not notify the physician of the tube feeding being held all night or of the resident's distended abdomen.	F 157		

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F 157	Continued From page 4 C/O #29026	F 157		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of hospital records, review of the facility investigation, facility policy review, review of inservice records, observation and interview, the facility failed to ensure staff did not place hot coffee within reach of one resident (#1) who required assistance with eating and supervision with hot beverages, resulting in harm from a second degree burn to resident #1 of six residents reviewed. The findings included: Resident #1 was admitted to the facility on November 29, 2010, with diagnoses including Osteoarthritis, Anemia, Subdural Hematoma (November 23, 2010), Dementia, Hypertension, Gastrointestinal Reflux Disease, Palpitations, History of Falls and Diabetes. Medical record review of the Minimum Data Set (MDS) dated January 7, 2012, revealed the resident had short and long-term memory problems; had difficulty focusing attention (easily	F 224	F 224 1. What corrective action(s) will be accomplished for those residents found to have been affected: On 3/1/12 CNA immediately placed towels between residents skin and clothing. LPN and CNA removed clothing in resident's room, applied wet towel to burned area, contacted physician and obtained treatment order for Silvadine which was applied, resident was sent to ER for further evaluation. On 3/1/12 the Executive Director, Department Heads, and Nursing Supervisors educated associates at All Staff meeting on the facility's policy for Reducing the Risk of Burns to Residents from Hot Beverages and on the facility's policy for placing resident trays in front of residents needing full assistance when the associate was ready to assist the resident. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On 3/1/12 and on 3/30/12 the Executive Director, Staff Development Coordinator (RN), Department Heads, and Nursing Supervisors educated nursing, rehab, dietary, environmental, social service, business office, admissions, health information, maintenance, recreation, and marketing associates on the facility's policy for Reducing the Risk of Burns to Residents from Hot Beverages and on the facility's policy for placing resident trays in front of residents needing full assistance when the associate was ready to assist the resident.	4/24/2012 4/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 5 distracted, out of touch or difficulty following what was said); had disorganized thinking; was short-tempered and easily annoyed; had Hallucinations and Delusions; had physical and verbal behavioral symptoms directed toward others and behavioral symptoms not directed towards others (hitting, rummaging, verbal symptoms like screaming, disruptive sounds), which significantly interfered with the resident's care and significantly disrupted others' care or the environment. Continued review of the MDS revealed the resident required extensive assistance with bed mobility, transfers, dressing, eating and hygiene; was totally dependent on staff for bathing; required a wheelchair for mobility; was incontinent of bowel and bladder; had no complaints of pain; and had no ulcers, wounds or other skin problems. Medical record of nurses' notes dated February 22, 2012 revealed, "...Must be fed per staff..." and February 27, 2012, "...Has to be fed all meals..." Review of a list provided by the facility on March 27, 2012, entitled "Residents requiring special supervision with hot liquids as of March 1, 2012", revealed resident #1 was included on the list. Medical record review of a dietary print-out (no date) revealed the resident received a regular, pureed diet with nectar thick liquids. Medical record review of pain assessments dated January 19, February 5 and 21, 2012, revealed the resident had no pain reported. Continued review revealed on March 1, 2012, the resident was "currently in pain."	F 224	F 224 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not reoccur? A licensed nurse is assigned to the dining room to supervise all meals. The licensed nurses' responsibility is to supervise the area and ensure that no meal trays are set up for a resident requiring assistance until the associate is ready to assist the resident. The assigned licensed nurse will sign the dining room assignment sheet daily for one month and then weekly for two months verifying that they supervised the area and that no trays were set up for a resident until the associate was ready to feed the resident and turn the sheet into the Director of Nursing or nursing (LPN or RN) daily. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. The Director of Nursing or designee will review the dining room assignment sheets daily and will report finding monthly times three months to the members of the Performance Improvement Committee including the Medical Director, Executive Director, Pharmacist, Director of Business Development, Business Office manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. They will review the findings, make recommendations, and make plans of action if any areas are found to be noncompliant.	4/24/2012 4/24/2012

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F 224	Continued From page 6 Medical record review of a nurse's note dated March 1, 2012, at 8:00 a.m., revealed, "...resident brought down to this nurse. CNA (Certified Nursing Assistant #1) helped nurse get resident to (room). Upon lying resident down on bed this nurse noted a large red/peeling area to (right) upper thigh. Dr. (name) called. N/O (New order) for Silvadene cream BID (twice daily) to (right) upper thigh until healed. Silvadene applied. When asked CNA what happened...said 'someone put resident's tray in front of her. She grabbed...coffee cup and spilled it on...lap...Resident's family requested resident to be sent to (hospital) for eval (evaluation) et (and) TX (treatment). EMS (Emergency Medical Service) here @ (at) 8:30 a.m..." Review of the hospital ER (Emergency Room) record dated March 1, 2012, revealed the resident had a second degree burn on the right lower extremity. Continued review revealed Lorcet (pain medication) was administered and an IV (intravenous) infusion of Normal Saline (NS) at 95 ml (milliliters) per hour was administered in the hospital emergency room. Medical record review of a nurse's note dated March 1, 2012, at 12:40 p.m., revealed the resident was returned to the facility "via EMS". Medical record review of physician's orders dated March 1, 2012, revealed, "one-time dose Hydrocodone (pain medication) 5/500 (milligrams) po (by mouth)", and "...Lorcet 1 tab (tablet) 5/325 q (every) 6 (hours) PRN (as needed) pain x (times) 2 wks (weeks)...NS @ (at) 75 ml/hr (hour) x 48 (hours)."	F 224		

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F 224	Continued From page 7	F 224		

Medical record review of the pain flow sheet revealed the following pain medications were administered for pain in the right thigh after the burn: March 2, at 9:00 a.m., Lorcet 5/325 mg for pain at "9+" intensity (zero being no pain and 10 being the worst pain on the pain scale); March 2, at 12:00 p.m., Lorcet 5/500 mg for "10+" intensity; March 2, at 3:00 p.m., Morphine Sulfate (MS) 5 mg subcutaneous for "10+" intensity; March 2, at 5:00 p.m., Tylenol 650 mg for "5+" intensity; March 2, at 6:35 p.m., MS 5 mg for "10+" intensity; March 3, at 12:55 a.m., MS 5 mg for "8-9" intensity; March 3, at 4:15 a.m., Tylenol for "6" intensity; March 3, at 8:00 a.m., MS 5 mg for "6" intensity; and March 5, (time not discernible) Lorcet 5/325 for "6" intensity.

Medical record review of a nurse's note dated March 5, 2012, at 5:50 p.m., revealed, "...New order noted to send to (hospital) ER per MD (Medical Doctor)..."

Medical record review of the facility's transfer record dated March 5, 2012, which was provided to the hospital revealed, "Reason for transfer: Pain management...Skin condition: 2nd and 3rd degree burns to right hip..."

Review of a hospital history and physical dated March 5, 2012, revealed, "...apparently suffered a burn after having some hot liquids spilled on (resident) a few days ago. It had been managed at the nursing home with some Silvadene Cream however it was not getting any better...was sent to the Emergency Room for evaluation. The Emergency Room physician reports that it had exudates present on the wound which was

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F 224	Continued From page 8 cleansed while there...apparently did have a foul smell to it as well...patient has severe Dementia...has an irregular shape second degree burn and one measuring approximately 4 cm (centimeters) x (times) 8 cm in length and another approximately 2 cm x 3 cm elliptical shape burn on the right hip area. Base is clean with some surrounding erythema..." Review of a hospital wound care report dated March 6, 2012, revealed, "...Patient with non-healing burn to right hip. Per family burn was caused by hot coffee at nursing home...Entire surface of burn measures 19x12 cm. Open area measures 16x5 cm. Unable to determine depth of wound due to presence of adherent yellow slough that covers 90% (percent) of open wound bed. Wound edges red. Small amount yellow drainage noted. Patient with two satellite wounds...wound to anterior lower abdomen measures 1x3 cm. Wound bed covered with adherent yellow (slough) to 100% of wound...Second...wound to posterior right thigh measuring 1.2x3 cm. Unable to determine depth due to 100% of wound bed being covered in adherent yellow slough. No odor noted to wounds..." Medical record review of a nurse's note dated March 8, 2012, at 2:30 p.m., revealed the resident returned to the facility. Medical record review of the physician's orders dated March 8, 2012, revealed, "...Ultram (pain medication) 50 mg po q 8 hours prn..." and "Wound care (with) Santyl Ointment for 5 days..." Medical record review of the Medication	F 224		

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F 224	Continued From page 9 Medical record review of the Medication Administration Record (MAR) dated March 8-25, 2012, revealed no documentation Ultram was administered. Medical record review of a signed physician's order dated April 16, 2012, and received from the facility on April 16, 2012, by fax revealed, "Hydrocodone 5/325 mg 1 tablet po q 6 hours as needed for pain. Effective 3-9-12." Medical record review of the pain flow sheet dated March 9, 2012, revealed Hydrocodone 5/325 was administered to the resident for pain in the right thigh, with movement, with intensity of "8". Medical record review of a nurse's note dated March 13, 2012, revealed, "...Resident lying in bed with knees bent and restless saying burning, burning-given pain medication po..." Medical record review of the pain flow sheet dated March 13, 2012, revealed the resident had pain in the right thigh with movement at intensity of "7", and Tylenol 650 mg was administered. Review of the facility investigation documented by the Administrator dated March 2, 2012, revealed the facility's investigation was "...being finalized...appeared that the tray was on the table, a tech (CNA-Certified Nursing Assistant #1) was across the table...patient was pushed up to the table and reached for coffee...there were four...people in the dining room when the event occurred..." Review of a written statement by CNA #1 dated	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 10	F 224		

March 1012, revealed, "While feeding (another resident) the (speech therapist (ST) told me (resident #1) grab her coffee and spelt (spilled) on...self. I got up and grabed (grabbed) some towels and put one down (resident #1's) pants to keep the hot coffee off...leg...then took...to...room and...took...pants off...put a wet towel on...leg."

Review of a written statement by CNA #2 dated March 1, 2012, revealed, "I was sitting at the front (dining room) feeding (another resident)...(CNA #3) was feeding (another resident)...(CNA #1) was sitting in the middle starting to feed (another resident)...and (resident #1) was sitting across the table. The Speech Therapist was feeding (another resident) when she stated, (resident #1) spelled (spilled) coffee on (self)..."

Review of a written statement by the ST dated March 2, 2012, revealed, "...was in the dining room for therapy with a patient...went to get my patient's tray when another resident's family member handed me (resident #1's) tray. I put the tray at the table where (resident #1) was to be fed. (Resident) was not pushed up to the table when I set the tray down. I then proceeded to give therapeutic feeding to my patient. During the therapy, I glanced up and noticed (resident #1) holding the coffee and it spilled in...lap. The tech who was at the table with (resident) got up and used towels to dry...then took down the hall. There was a tech present at the table when the incident occurred. Other techs were present in the dining room who were not feeding anyone and were not supervising."

Review of a written statement by CNA #3 dated March 12, 2012, revealed, "...I was at the second

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	445167	A. BUILDING _____ B. WING _____	C 04/18/2012

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LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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F 224	Continued From page 11 door by the front feeding (another resident)...somebody had set (resident #1's) tray in front of (resident), and the speech lady said (resident) spilled...coffee on (self)..." Review of the facility's policy entitled, "Reducing the Risk of Burns to Residents from Hot Beverages" revealed, "Training objective: Participants will identify ways to reduce the risk of residents sustaining burns from hot beverages...Because burns can result from hot liquids that are 120 (degrees) F (Fahrenheit) or above, supervision is required to provide a safe environment...Hot beverages should be available to residents only in areas that are supervised at all times. Supervised areas may include: Dining rooms...Evaluate each resident's ability to manage hot beverages, and provide needed assistance. Keep the list of residents who need special supervision current...Develop a process to ensure that all associates involved with dining...are aware of who needs this special supervision..." Review of the inservice record dated March 1, 6 and 9, 2012, revealed, "...The associate who is assigned to feed a patient should bring the tray with them to the patient's table or bedside and feed the patient at that time. Trays should not be present at the table until the associate is ready to sit down with the patient and help them to eat...The attached policies for Reducing the Risk of Burns to Residents from Hot Beverages...should be followed." Observation on March 26, 2012, at 8:55 a.m., with Licensed Practical Nurse (LPN) #2/Treatment Nurse revealed the resident lying in	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING _____ B. WING _____	C 04/18/2012

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F 224	Continued From page 12	F 224		

bed and revealed a wound to the right thigh which the Treatment Nurse measured as 8.0 cm x 1.0 cm by unstageable depth with 5-10% granulation.

Observation on March 26 2012, at 12:15 p.m., revealed the resident sitting in a wheelchair near the nurses' station with non-purposeful movements including fidgeting with the pants. The pants were above the resident's knees. Observation revealed no response to communication with the resident.

Review of the weekly wound report and interview on March 26, 2012, at 8:10 a.m., in the conference room, with the LPN #2/Treatment Nurse confirmed the resident was "burned with hot coffee." Continued interview revealed the wound had been measured by LPN #2/Treatment Nurse on March 26, 2012, prior to 8:10 a.m., and the wound measured 8.0 cm x 1.0 cm x unstageable.

Interview on March 26, 2012, at 2:20 p.m., in the conference room, with CNA #1 revealed on March 1, 2011, CNA #1 "had just walked into dining room-running late" for the second meal setting. Continued interview revealed the CNA sat down to feed another resident when the ST told CNA #1 that resident #1 spilled coffee on self. The CNA stated, "jumped up and got a couple of bibs-lifted pants to get coffee off...put bibs between (resident's) pants and leg...ended up burning my left hand...blisters on my fingers...When I saw leg, I knew it was second degree burns...skin coming off...steam coming off (resident's) pants." Continued interview confirmed the resident was a "grabber...likes grabbing everything. Everybody knows...grabs everything.

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	445167	A. BUILDING _____ B. WING _____	C 04/18/2012

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F 224	Continued From page 13 I don't know who sat the tray down but everybody knows she's a grabber." Continued interview confirmed the second meal settings in the dining room were "mostly" for residents who required feeding. CNA #1 stated, "When it happened, (resident) was yelling. You could tell she was hurting...still yelling down the hall and after...got in bed..." Interview on March 26, 2012, at 3:10 p.m., in the conference room, with the ST confirmed on March 1, 2012, the ST was feeding a resident in the dining room and observed resident #1 spill hot coffee on (resident #1). Continued interview confirmed the ST had knowledge the resident was a "grabber, but I don't know how purposeful..." Continued interview confirmed other staff was in the dining room "who were supposed to be monitoring the situation..." Telephone interview on March 26, 2012, at 7:20 p.m., with CNA #2 confirmed CNA #2 was feeding a resident in the dining room on March 1, 2012, at the time resident #1 received the burn from hot coffee. Continued interview confirmed the facility's policy required trays not be placed in front of a resident (who required feeding) until staff was ready to feed the resident. Continued interview confirmed the resident was "all the time holding the arms out reaching...constantly reaching for things..." Review of the ST's written statement dated March 2, 2012, and interview on March 27, 2012, at 8:13 a.m., in the conference room, with the ST confirmed the ST's written statement and confirmed the ST sat the resident's breakfast tray on the table in front of the resident. The ST	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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F 224	Continued From page 14	F 224		

stated, "When I placed the tray down (resident) was not pushed up to the table for feeding." Continued interview revealed, "The techs who were not feeding were in the dining room and suppose to be supervising residents. The techs who were not feeding were not supervising otherwise they would have seen (resident) had the meal tray and would have removed the tray until someone was ready to feed (resident)..."

Telephone interview on March 27, 2012, at 3:15 p.m., with CNA #3 confirmed CNA #3 was feeding another resident on March 1, 2012, at the time resident #1 received the burn from hot coffee. Continued interview confirmed, "If there's something (resident #1) can reach...will grab it...have seen...jerk flower off table many times...constantly reaching..." Continued interview confirmed, "Everyone in there (in dining room at the time of the burn) was either feeding or starting to feed. No one was standing to supervise. (Resident #1) was "total feeder." Continued interview confirmed the facility's policy required trays not be placed in front of a resident (who required feeding) until staff was ready to feed the resident.

Telephone interview on March 29, 2012, at 1:05 p.m., with LPN #1, who was on duty on March 1, 2012, at the time of the burn, revealed when LPN #1 first observed the resident, the area "was already blistered." LPN #1 notified the physician and received orders to apply Silvadene cream. Continued interview confirmed the resident was "squirming every time air was hitting it (burn) when I was putting cream on it." Continued interview confirmed the resident was constantly reaching and grabbing since LPN #1 had been

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LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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F 224	Continued From page 15 employed (2010). Continued interview confirmed the resident was "a feeder"; received nectar thick liquids; and required supervision for feeding and hot liquids. Continued interview confirmed the facility's policy required trays not be placed in front of a resident (who required feeding) until staff was ready to feed the resident. Interview on March 27, 2012, at 4:00 p.m., in the conference room, with the Director of Nursing (DON), in the presence of the Administrator and the Regional Director of Clinical Services, confirmed the resident required supervision with hot beverages on March 1, 2012, the day the resident received the burn from hot coffee and confirmed the facility's policy at the time of the burn required meal trays not be served to a resident who required feeding until staff were ready to sit down and feed the resident. Continued interview confirmed the second meal service in the dining room was for residents who required supervision and, "That's why they're in that setting."	F 224		
F 281 SS=D	C/O #29490 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, review of a facility investigation and interview, the facility failed to follow the physician's orders and facility policy to administer	F 281	F 281 1. What corrective action(s) will be accomplished for those residents found to have been affected: Resident #1 had a bowel movement on January 9, 2012. Resident #2 -Director of Nursing provided one on one education with LPN #3 regarding following MD orders for tube fed residents on 11/23/11.	4/24/2012

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LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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F 281	Continued From page 16 a laxative or enema to one resident (#1) with no recorded bowel movement for three days and failed to follow the physician's order for tube feeding for one resident (#2) of six residents reviewed. The findings included: Resident #1 was admitted to the facility on November 29, 2010, with diagnoses including Osteoarthritis, Anemia, Subdural Hematoma (November 23, 2010), Dementia, Hypertension, Gastrointestinal Reflux Disease, Palpitations, History of Falls and Diabetes. Medical record review of the Minimum Data Set (MDS) dated January 7, 2012, revealed the resident had short and long-term memory problems; required extensive assistance with bed mobility, transfers, dressing, eating and hygiene; was totally dependent on staff for bathing; and was incontinent of bowel and bladder. Medical record review of the signed, physician's standing orders (no date) revealed, "...Constipation: MOM (Milk of Magnesia) 30 cc (cubic centimeter) po (by mouth) daily prn (as needed)...Dulcolax suppository q (every) 3rd day w/o (without) BM. Soap suds enema q 3rd evening w/o BM..." Medical record review of the bowel record dated January 1-31, 2012, revealed no documentation the resident had a bowel movement from day shift on January 5, 2012, until day shift, January 9, 2012 (four days). Medical record review of nurses' notes dated	F 281	F 281 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Resident #1 Effective 4/24/12 the Director of Nursing or Nursing Supervisor (LPN or RN) will review daily for one month and two time weekly for two months the daily "Missing Bowel Movement Report" and ensure interventions are in place. 4/23/12 the Medical Director revised the facility standing orders to read "may give MOM 30 cc PO or dulcolax supp after 3rd day without a BM and notify MD". Resident #2 On 4/12/12 the Director of Nursing audited residents charts who were receiving tube feeding to verify that MD orders for tube feeding were followed as written with no issues observed. On 12/8/11 and 3/30/12 the Staff Development Coordinator (RN) and Nursing Supervisor educated licensed nurses (LPN or RN) on following physician orders for tube feeding. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not reoccur? Resident #1 On 4/23/12 the Staff Development Coordinator (RN) and Nursing Supervisors initiated education to licensed nurses (LPN and RN) on bowel protocol.The "Missing Bowel Movement Report" will be audited for compliance by the Director of Nursing or Nursing Supervisor daily for one month and then two times weekly for two months. Resident #2 A licensed nurse will complete an audit daily for one month, then weekly for two months of physician orders for tube feeding to ensure compliance.	4/24/2012 4/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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F 281	Continued From page 17 January 3-14, 2012, revealed no documentation the resident had a bowel movement from January 5, 2012, until January 9, 2012, and no documentation a laxative was administered. Medical record review of the Medication Administered Record (MAR) dated January -31, 2012, revealed no documentation a laxative or suppository was administered on January 8, 2012. Review of the facility's BM (bowel movement) policy revealed, "...The facility will provide appropriate interventions for signs and symptoms of Constipation...Nursing staff will document the resident's bowel movements each shift...evening shift will assess the bowel movement data daily and respond accordingly to the protocol and/or per physician's orders...If no bowel movement is recorded for 3 days: Administer PRN (as needed) laxative or enema as ordered by physician...If no PRN is ordered contact physician, inform of the resident's status and request a PRN laxative order..." Medical record review and interview on March 27, 2012, at 2:00 p.m., in the conference room, with the Director of Nursing (DON) confirmed no evidence the resident had a bowel movement from day shift on January 5, 2012, until day shift on January 9, 2012, and a laxative or enema was not administered on January 8, 2012 (third day). Continued interview confirmed the facility's policy and physician's orders were not followed. Resident #2 was admitted to the facility on August 25, 2005, with diagnoses including Senile Delusions, Hypertension, Urinary Retention,	F 281	F 281 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place. Resident #1The Director of Nursing or designee will review the "Missing Bowel Movement Report" audit and will report findings monthly times three months to the members of the Performance Improvement Committee including the Medical Director, Executive Director, Pharmacist, Director of Business Development, Business Office manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. They will review the findings, make recommendations, and make plans of action if any areas are found to be noncompliant. Resident #2 The Director of Nursing or designee will review the tube feeding orders audit and will report findings monthly times three months to the members of the performance improvement meeting including the Medical Director, Executive Director, Pharmacist, Director of Business Development, Business Office manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. They will review the findings, make recommendations, and make plans of action if any areas are found to be noncompliance.	4/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 18 Severe Alzheimer's Disease, Diabetes, Cerebral Vascular Accident (Stroke), History of Melanoma, History of Hypotensive Shock and Respiratory Arrest requiring ventilation and PEG (Percutaneous Endoscopic Gastrostomy) tube placement (August 2005). Medical record review of the MDS dated January 7, 2012, revealed the resident had short and long-term memory problems and severely impaired decision-making skills; had no behavioral symptoms; was totally dependent on staff (one to two staff) for all activities of daily living (ADL); required a feeding tube with 51% (percent) or more total calories provided with tube feeding; and had an average fluid intake by tube feeding of 501 cc (cubic centimeter) or more per day. Medical record review of the physician's recapitulation orders dated November 1-30, 2011, revealed, "...Glucerna (prepared tube feeding)...60 ml (milliliter) (per) hour (720 ml per twelve hour nursing shift)...Check residual every 4 hours-If greater than 100 ml, turn feeding off for 2 hours then restart..." Medical record review of the care plan dated January 2012 revealed, "At increased risk for dehydration/fluid imbalance and for aspiration due to dysphagia requiring PED tube for fluid and nutritional intake...Feeding formula and rate as ordered..." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated November 4, 2011, at 10:00 p.m., revealed, "...feeding held due to more than 30 cc	F 281		

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F 281	Continued From page 19 residual-Abd (Abdomen) distended-Will monitor (with) feeding off." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated November 13, 2011, at 10:00 p.m., revealed, "...Feeding pump off @ (at) this time due to residual (no amount documented) and shaking hands...G (Gastrostomy) tube patent & (and) intact..." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated November 18, 2011, at 10:00 p.m., revealed, "...noted 60 cc plus residual-feeding held-tube patent & flushed well-will continue to monitor." Review of the tube feeding intake and output flowsheet revealed the following: November 4, 2011, 250 cc tube feeding was administered 6:00 p.m.-6:00 a.m., (night shift) by LPN #3; November 13, 2011, 100 cc tube feeding was administered by LPN #3 on night shift; and November 18, 2011, LPN #3 held the tube feeding "due to lg (large) amt (amount) residual (amount not documented)". Medical record review of the resident's weight record October 3-December 5, 2011, revealed the resident had no weight loss and weighed 151 lbs. (pounds) on October 3, 2011; 152 lbs. on November 1, 2011, and 152 lbs. December 5, 2011. Review of the facility investigation (timeline) dated November 21, 2011-December 7, 2011, confirmed LPN #3 held the tube feeding on November 4, 13 and 18, 2011.	F 281		

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F 281	Continued From page 20 Medical record review and interview on March 27, 2012, at 10:45 a.m., in the conference room, with LPN #3 confirmed the physician ordered the tube feeding held for two hours if the residual was 100 cc. Continued interview confirmed LPN #3 had no prior knowledge the physician's order for holding the tube feeding was for residual of 100 cc. Continued interview confirmed LPN #3 held the tube feeding on November 4, 2011, at 10:00 p.m. with a residual of 30 cc. Continued interview confirmed LPN #3 held the tube feeding on November 13, 2011, because the resident's hands were shaking and LPN #3 was "afraid would go into Seizures and aspirate." Continued interview confirmed LPN #3 held the tube feeding on November 18, 2011, with a residual of 60 cc. Continued interview confirmed LPN #3 left the tube feeding "off all night" on November 18, 2011. Continued interview with LPN #3 confirmed the LPN failed to follow physician's orders for tube feeding.	F 281		
F 323 SS=G	C/O #29026, #29490 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of hospital records, review of the facility investigation, facility policy review, review of inservice records, observation and interview, the facility failed to ensure hot coffee was not placed within reach of one resident (#1), who required supervision with hot beverages, resulting in a second degree burn of resident #1 of six residents reviewed. The facility's failure resulted in harm for resident #1. Resident #1 was admitted to the facility on November 29, 2010, with diagnoses including Osteoarthritis, Anemia, Subdural Hematoma (November 23, 2010), Dementia, Hypertension, Gastrointestinal Reflux Disease, Palpitations, History of Falls and Diabetes. Medical record review of the Minimum Data Set (MDS) dated January 7, 2012, revealed the resident had short and long-term memory problems; had difficulty focusing attention (easily distracted, out of touch or difficulty following what was said); had disorganized thinking; was short-tempered and easily annoyed; had Hallucinations and Delusions; had physical and verbal behavioral symptoms directed toward others and behavioral symptoms not directed towards others (hitting, rummaging, verbal symptoms like screaming, disruptive sounds), which significantly interfered with the resident's care and significantly disrupted others' care or the environment. Continued review of the MDS revealed the resident required extensive assistance with bed mobility, transfers, dressing, eating and hygiene; was totally dependent on	F 323	F 323 1. What corrective action(s) will be accomplished for those residents found to have been affected: On 3/1/12 CNA immediately placed towels between residents skin and clothing. LPN and CNA removed clothing in resident's room, applied wet towel to burned area, contacted physician and obtained treatment order for Silvadine which was applied, resident was sent to ER for further evaluation. On 3/1/12 the Executive Director, Department Heads, and Nursing Supervisors educated associates at All Staff meeting on the facility's policy for Reducing the Risk of Burns to Residents from Hot Beverages and on the facility's policy for placing resident trays in front of residents needing full assistance when the associate was ready to assist the resident. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On 3/1/12 and on 3/30/12 the Executive Director, Staff Development Coordinator (RN), Department Heads, and Nursing Supervisors educated nursing, rehab, dietary, environmental, social service, business office, admissions, health information, maintenance, recreation, and marketing associates on the facility's policy for Reducing the Risk of Burns to Residents from Hot Beverages and on the facility's policy for placing resident trays in front of residents needing full assistance when the associate was ready to assist the resident.	4/24/2012 4/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 22 staff for bathing; required a wheelchair for mobility; was incontinent of bowel and bladder; had no complaints of pain; and had no ulcers, wounds or other skin problems. Medical record of nurses' notes dated February 22, 2012 revealed, "...Must be fed per staff..." and February 27, 2012, revealed, "...Has to be fed all meals..." Review of a list provided by the facility on March 27, 2012, entitled "Residents requiring special supervision with hot liquids as of March 1, 2012", revealed resident #1 was included on the list. Medical record review of a dietary print-out (no date) revealed the resident received a regular, pureed diet with nectar thick liquids. Medical record review of a nurse's note dated March 1, 2012, at 8:00 a.m., revealed, "...resident brought down to this nurse. CNA (Certified Nursing Assistant #1) helped nurse get resident to (room). Upon lying resident down on bed this nurse noted a large red/peeling area to (right) upper thigh. Dr. (name) called. N/O (New order) for Silvadene cream BID (twice daily) to (right) upper thigh until healed. Silvadene applied. When asked CNA what happened...said 'someone put resident's tray in front of her. She grabbed...coffee cup and spilled it on...lap...Resident's family requested resident to be sent to (hospital) for eval (evaluation) et (and) TX (treatment). EMS (Emergency Management Service) here @ (at) 8:30 a.m..." Refer to F224	F 323	F 323 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? A licensed nurse is assigned to the dining room to supervise all meals. The licensed nurses' responsibility is to supervise the area and ensure that no meal trays are set up for a resident requiring assistance until the associate is ready to assist the resident. The assigned licensed nurse will sign the dining room assignment sheet daily for one month and then weekly for two months verifying that they supervised the area and that no trays were set up for a resident until the associate was ready to feed the resident and turn the sheet into the Director of Nursing or nursing (LPN or RN) daily. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place. The Director of Nursing or designee will review the dining room assignment sheets daily and will report finding monthly times three months to the members of the Performance Improvement Committee including the Medical Director, Executive Director, Pharmacist, Director of Business Development, Business Office manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. They will review the findings, make recommendations, and make plans of action if any areas are found to be noncompliant.	4/24/2012 4/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. BUILDING _____ B. WING _____	C 04/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CROSSVILLE	80 JUSTICE ST CROSSVILLE, TN 38555

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F 323	Continued From page 23 C/O #29490	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review and interview, the facility failed to maintain an accurate medical record for one (#2) of six residents reviewed. The findings included: Resident #2 was admitted to the facility on August 25, 2005, with diagnoses including Senile Delusions, Severe Alzheimer's Disease, Diabetes, Cerebral Vascular Accident (Stroke), and PEG (Percutaneous Endoscopic Gastrostomy) tube placement (August 2005). Medical record review of the Minimum Data Set (MDS) dated January 7, 2012, revealed the resident had short and long-term memory	F 514	F 514 1. What corrective action(s) will be accomplished for those residents found to have been affected: On 12/8/11 and 3/30/12 the Staff Development Coordinator (RN) and Nursing Supervisors educated licensed nurses (LPN and RN) on proper documentation for tube feeding. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Director of Nursing audited resident charts for residents receiving tube feeding for proper documentation on 4/12/12 with no issue observed. On 12/8/11and 3/30/12 the Staff Development Coordinator (RN) and Nursing Supervisors provided education to licensed nurses (LPN and RN) regarding proper documentation for tube feeding in the medical record. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? The Director of Nursing or nursing supervisor will complete an audit daily for one month, then weekly for two months of daily documentation regarding tube feeding.	4/24/2012 4/24/2012 4/24/2012

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F 514	Continued From page 24 problems and severely impaired decision-making skills; required a feeding tube with 51% (percent) or more total calories provided with tube feeding; and had an average fluid intake by tube feeding of 501 cc (cubic centimeter) or more per day. Medical record review of the physician's recapitulation orders dated November 1-30, 2011, revealed, "...Glucerna (prepared tube feeding)...60 ml (milliliter) (per) hour (720 ml per twelve hour nursing shift)...Check residual every 4 hours-If greater than 100 ml, turn feeding off for 2 hours then restart..." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated November 4, 2011, at 10:00 p.m., revealed, "...feeding held due to more than 30 cc (cubic centimeter) residual-Abd (Abdomen) distended-Will monitor (with) feeding off." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated November 13, 2011, at 10:00 p.m., revealed, "...Feeding pump off @ (at) this time due to residual (no amount documented) and shaking hands...G (Gastrostomy) tube patent & (and) intact..." Medical record review of a nurse's note by Licensed Practical Nurse (LPN) #3 dated November 18, 2011, at 10:00 p.m., revealed, "...noted 60 cc plus residual-feeding held-tube patent & flushed well-will continue to monitor." Review of the tube feeding intake and output flowsheet revealed the following: November 4, 2011, 250 cc tube feeding was administered 6:00	F 514	F 514 4. How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur; i.e., what quality assurance program will be put into place. The Director of Nursing or designee will review the tube feeding documentation audit and will report findings monthly times three months to the members of the Performance Improvement Committee including the Medical Director, Executive Director, Pharmacist, Director of Business Development, Business Office manager, Director of Admissions, Director of Environmental Service, Director of Health Information, Director of Recreational Services, Director of Maintenance, Director of Social Services, and Staff Development Coordinator. They will review the findings, make recommendations, and make plans of action if any areas are found to be noncompliant.	4/24/2012

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F 514	Continued From page 25	F 514		

p.m.-6:00 a.m., (night shift) by LPN #3; November 13, 2011, 100 cc tube feeding was administered by LPN #3 on night shift; and November 18, 2011, LPN #3 held the tube feeding "due to lg (large) amt (amount) residual (no amount documented)".

Medical record review and interview on March 27, 2012, at 10:45 a.m., in the conference room, with LPN #3 revealed LPN #3 denied holding the tube feeding "all night" on November 4, 2011, and stated, "I made a mistake on November 4th in documenting the amount of tube feeding given. I only held 250 cc that night...meant to write down 500 something I think she got."

Continued interview with LPN #3 confirmed the medical record for November 13, 2011, was incomplete and inaccurate and stated, "The tube feeding was probably restarted a couple of hours later" after the resident had been observed with the hands shaking.

Continued interview confirmed the medical record was incomplete and inaccurate for November 18, 2011, and revealed LPN #3 "checked residual" and failed to document the results three times on night shift.

C/O #29026